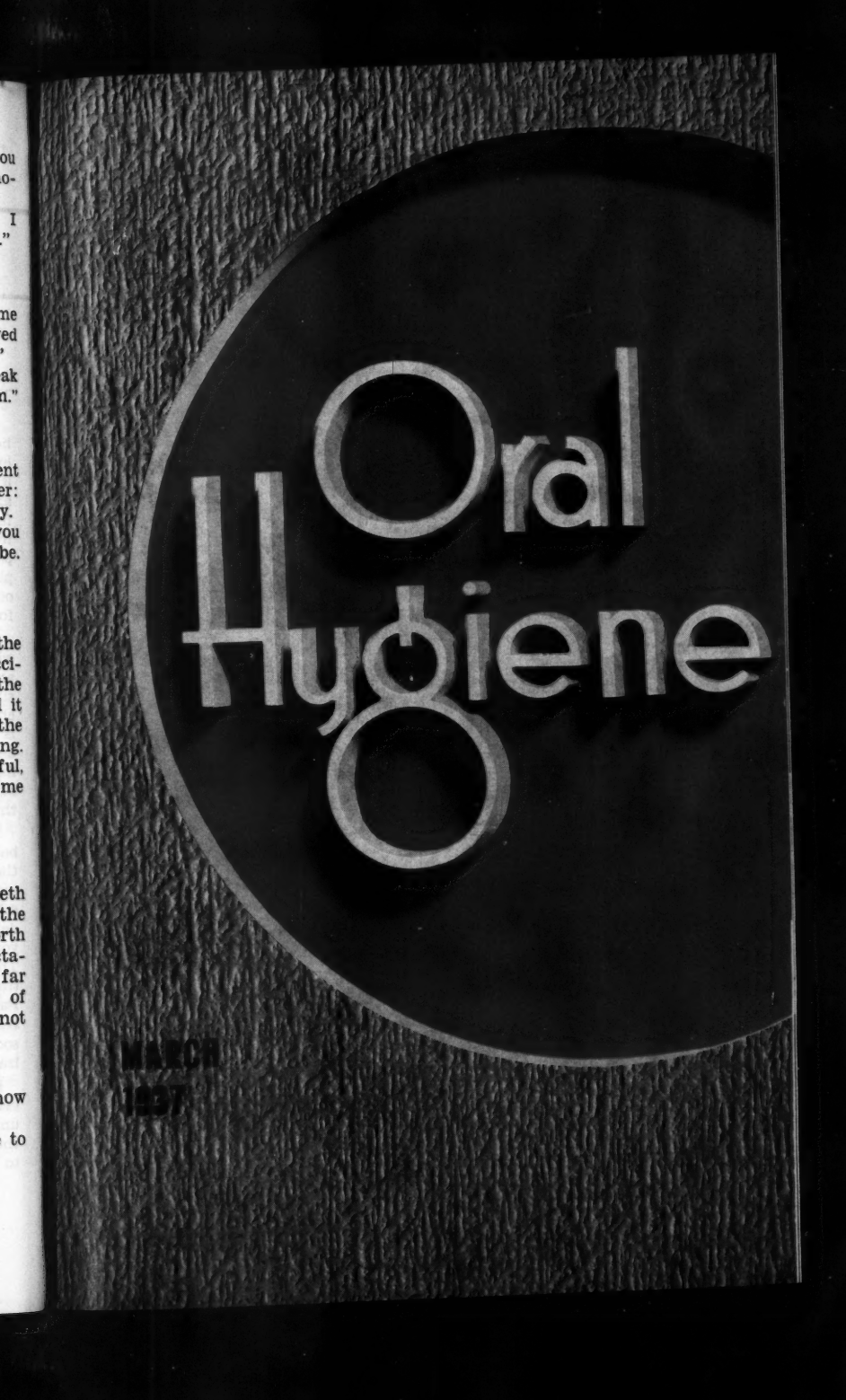
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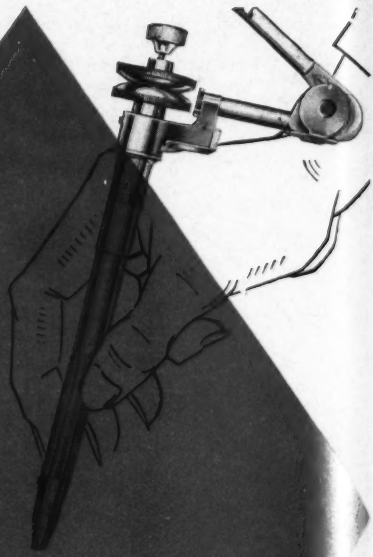
balanced Sani-Terry



At the point where a handpiece is naturally grasped when it is in use, the weight of the Sani-Terry Handpiece is exactly balanced. There is no unnecessary fatigue of the operator's hand from the backward drag of unbalanced weight. Control is easier and more accurate.

Sani-Terry Handpieces have no unnecessary bulk or weight, but are unusually resistant to wear. They are true-running, smooth in operation, unusually free from vibration. Discomfort is lessened for the patient when Sani-Terry Handpieces are used; there is less fatigue for the operator.

THE *Cleveland* DENTAL MANUFACTURING CO.

CLEVELAND, OHIO U.S.A.

VOL. 27, NO. 3

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From MOUTH *To* MICROPHONE

by REA PROCTOR McGEE, D.D.S., M.D.*

WHEN WILLIAM A. BACHER (pronounced Baker) graduated from the University of Illinois College of Dentistry in 1919, he decided to practice dentistry for ten years and then, if nothing happened, go on and practice dentistry some more. He passed both the New York and New Jersey State Board examinations. For a few months he practiced in New York City and then went to Bayonne, New Jersey, where he was more than usually successful.

To use up his spare energy, he studied law and was admitted to the New Jersey Bar.

His dental practice was now and then interrupted by the combination of Doctor Bacher and Lawyer Bacher appearing for the defense in dental and medical malpractice suits.

One Friday night in 1927, Doctor Bacher attended his first radio broadcast in New York. He had been an early radio enthusiast, but this was the first time he had been right in where the music was made. After the broadcast Doctor Bacher interviewed the director who asked if he had any suggestions to make—

"Well yes I have," replied Bacher, "I think it would be a good idea to have a definite plan for the show, instead of making it up as you go along."

"My dear sir!" exclaimed the director, "I work altogether from original scripts for which I pay from $100.00 to $300.00 each."

"That being the case, what subject do you expect to tackle next?" inquired the interested spectator.

"Children's stories," answered the director.

"Tomorrow afternoon I will have a story in your hands."

Doctor Bacher returned to his hotel, wrote all night, and on Saturday he left his first radio script with the director. The same day he returned to his home in Bayonne.

On Monday he received a telephone call from his new friend notifying him of the acceptance of his story. On Tuesday the check arrived. Doctor Bacher then wrote a number of children's stories which were accepted and paid for, but never produced.

*Drawings by the author

Photograph Courtesy of D'Gaggeri Studio, Beverly Hills, California

WILLIAM A. BACHER, D. D. S.

These stories later appeared in book form, published by the sponsor for the program.

In a short time Doctor Bacher's radio stories plus his dental practice kept him working from sixteen to eighteen hours each day.

Presently, he was managing four short programs weekly and trying to practice his profession.

This was too great a demand upon his strength, so he sold the dental practice and devoted his time to radio.

His first original broadcasts were the "Eno Crime Club," followed by "Famous Trials of History."

His legal training made it possible for him to write and properly stage these famous trials. Millions of radio listeners hope that some day Doctor Bacher will continue this series.

The "Famous Trials of History" were sponsored by the National Dairy Products Corporation in 1931. The first trial was that of Benedict Arnold, charged with treason.

Clarence Darrow appeared as prosecuting attorney and the Honorable James M. Beck, Congressman from Pennsylvania, for the defense. Twelve distinguished men sat as the jury—Arnold was found guilty.

The next trial was that of Napoleon Bonaparte, charged with the murder of the Duke of Enghein. Mr. Arthur Garfield Hays prosecuted and Mr. Dudley Field Malone defended. Napoleon was acquitted.

The third trial was that of Aaron Burr charged with treason. In this trial the "flash back" to show previous history was used for the first time in radio broadcasting. Burr was found guilty of treason against the United States.

Radio engagements began to increase in number. At one time Doctor Bacher was writing and producing the weekly appearances of "Show Boat" (the title was rented from the author of the novel but the radio material was written by Doctor Bacher); The Palmolive Beauty Box Series; Lannie Ross, "Log Cabin"; and Maria Certo, "Matinee"—four radio programs each week by the same man.

A Brief Interruption

The result of this intensive work was just what you would expect, Doctor Bacher went to the hospital to have treatment for ulcers of the stomach.

When he recovered, the big opportunity came. Doctor Bacher for a long time will have a diet mainly of soup and milk. What was more appropriate than for the Campbell Soup Company to sign him up to produce the weekly broadcast, "Hollywood Hotel," over a national network?

The whole responsibility for "Hollywood Hotel" rests on Doctor Bacher. He writes the script, picks the artists, musicians, and important employees. He even picks the spot on which each performer plays his part.

He has a full orchestra with a routine leader, a master of ceremonies, Dick Powell, and a guest star impressario who is none other than Luella O. Parsons, the

famous Hollywood columnist.

On "Hollywood Hotel" night the theater hums with action, front stage and back stage. Everything is arranged with precision. The microphones are set at strategic points; the actors and musicians are trained to do their work at exactly the right moment and to finish on the split second. Every prominent member of the cast is played up by name, except Doctor Bacher. He still holds to his old professional ethics of no publicity. Ninety per cent of the people who attend the theater to see as well as hear the broadcasts wonder who the man in the center of the stage might be.

The responsibility that Doctor Bacher carries in the management of the "Hollywood Hotel" broadcast can be appreciated when you realize that ten million people listen in every Friday night. The weekly expense is $21,000 and Doctor Bacher's salary is equal to that of the President of the United States.

In the National Program Rating "Hollywood Hotel" has risen from thirty-eighth place to third place.

The story of Doctor Bacher's achievement in taking over this program is briskly told by Katharine Hartley[1] in the article "The Man Behind Hollywood Hotel"

published in the *Radio Guide* for November 28, 1936:

"Something was wrong in 'Hollywood Hotel.' The program was ablaze with petty jealousies, petty arguments, petty complaints. Everybody wanted to be starred, everybody wanted to rewrite the script.

"Then as a last resort Bacher was sent for. Bill Bacher, the biggest little man in radio. The man who had produced 'Show Boat' and the 'Beauty Box Revue.' The ex-dentist from Bayonne, New Jersey, who, in four short years, has made himself known throughout the ether world as a program doctor *de luxe*. Bill could save 'Hollywood Hotel'—if anyone could.

"A frantic SOS reached Bacher

[1]Hartley, Katharine: The Man Behind Hollywood Hotel, Radio Guide, Page 31 (November 28) 1936.

in New York. He shook his Harpo Marx head and said: 'I don't know whether I can do anything for 'Hollywood Hotel' or not. I'll tell you after I meet Dick Powell.' (He took a plane that night for Hollywood.)

"That was unprecedented. Instead of leaping at a fat contract and looking afterward—Bill Bacher looked first. He sat on the edge of Dick Powell's swimming pool, wiggling his pale New York toes in the blue Hollywood water. He looked for temperament. He looked for selfishness. He looked for ego and trouble. His search turned out to be as futile as an Everest climb.

"'O.K., Dick,' he said finally. 'You are all right with me.' That evening the contract was signed.

"But Dick was only one of seventy-five people on that show. Bill Bacher had to get to know each of the others, and he had to win their confidence. It was an almost super-human task—melting seventy-five scratching, kicking, hair-pulling personalities into one homogeneous mass—but Bill Bacher did it.

"He did it by the seemingly simple device of learning all there was to know about everyone of his people.

"In four months, 'Hollywood Hotel' jumped to fourteenth place on the Crosley list! Today it ranks among the first ten!"

It takes genius to do this job.

Genius consists of hard work—then more hard work, backed up by intelligence, imagination, comprehensive knowledge of the subject, enthusiasm; quick, accurate, judgment and dependability. All of these qualities Doctor Bacher shows daily in his radio work and, in addition, a surprising ability to get and hold the affections and cooperation of his staff of fifty or more artists, musicians and stage workers, who make the broadcasts a success.

The other night I went to see Doctor Bacher produce his show at the Ebell Theater in Los Angeles. The audience remains absolutely silent so as not to interfere with the sound transmission over the microphone.

Bacher stands on a box in the center of the stage with a substantial music rack in front of him. On that rack is the typewritten manuscript of the show. The actors all carry manuscripts in

their hands; as each page is spoken there is a silent flutter of paper to the floor.

Behind that music rack, Doctor Bacher is in action, directing silently, but with great energy. The silence requires gestures that are gestures. Bacher's flying hands and swaying body, his facial expressions, clutching, pointing, shivering fingers and last, but not least, swinging head, and flying hair, let his cast know when and where they come in and particularly when they go out.

As the tension lets down a little, a quiet little fellow holds up a sign that says: APPLAUSE.

The audience always responds.

This year Doctor Bacher received the "Distinguished Service Medal" of radio. He is the first non-performer to receive this award.

With all of his work and responsibility it is no wonder that Doctor Bacher does not get time to keep up his dental connections as he would like to do.

He still maintains his membership in the New Jersey State Dental Association and in the American Dental Association. In his few moments of relaxation he likes to discuss dentistry.

In his Beverly Hills home, he writes his stories and arranges his programs. He is fortunate in having a delightful wife who is intensely interested in his work and whose ability and tact make it possible for her to relieve Doctor Bacher of innumerable duties, so that now and then he can get a little rest.

It is pleasing to know that a capable and ethical dentist has stepped into this ultramodern world of radio to become one of the most famous impresarios of the air.

6381 *Hollywood Boulevard*
Hollywood, California.

DENTISTRY *Must Be* SALABLE

by W. A. MOLINE, D.M.D.

You now *sell* inlays, crowns, bridges, dentures, prophylaxes, and treatments.

Instead, the public should come to you to *buy* sound oral health and comfortable, well appearing dental restorations.

Doctor Louis Hill asks this question: "How can we make dentistry more buyable, not salable?"

The answer to this most significant question lies in one all important direction of activity—education.

How long will dentistry take to emerge from the cocoon and start spinning the silken strands to form a stronger bond between the dentist and his patients?

Of primary importance to our future is the creation of friendliness of the public toward our profession. This can be accomplished through a universal understanding of the dentist's motives of service to the public.

The need for dentistry to tell its story to the public is becoming more urgent each day. Many writers and dentists feel that, if some intelligent effort is not started soon, the time will arrive when it will be too late. Doctor George Wood Clapp[1] in his article, "Help Yourself to a Practice" in the November issue of Oral Hygiene says, "Dentistry's stories must be told. The public needs them almost more than any other form of health service. We also need them. We can have as large a regular audience as we are willing to cultivate by combined and continued efforts." It is imperative for the future welfare of dentistry that more dentists emulate the opinion and clear thinking of Doctor Clapp.

We like to think of dentistry as our profession, our contribution to the welfare of humanity. But never for a moment should we lose sight of the fact that it is also a business. And with certain restrictions it should be treated as a business. Let us call dentistry professional business. This paper will deal with advertising and publicity in the business of dentistry and the relation of the dentist to the public.

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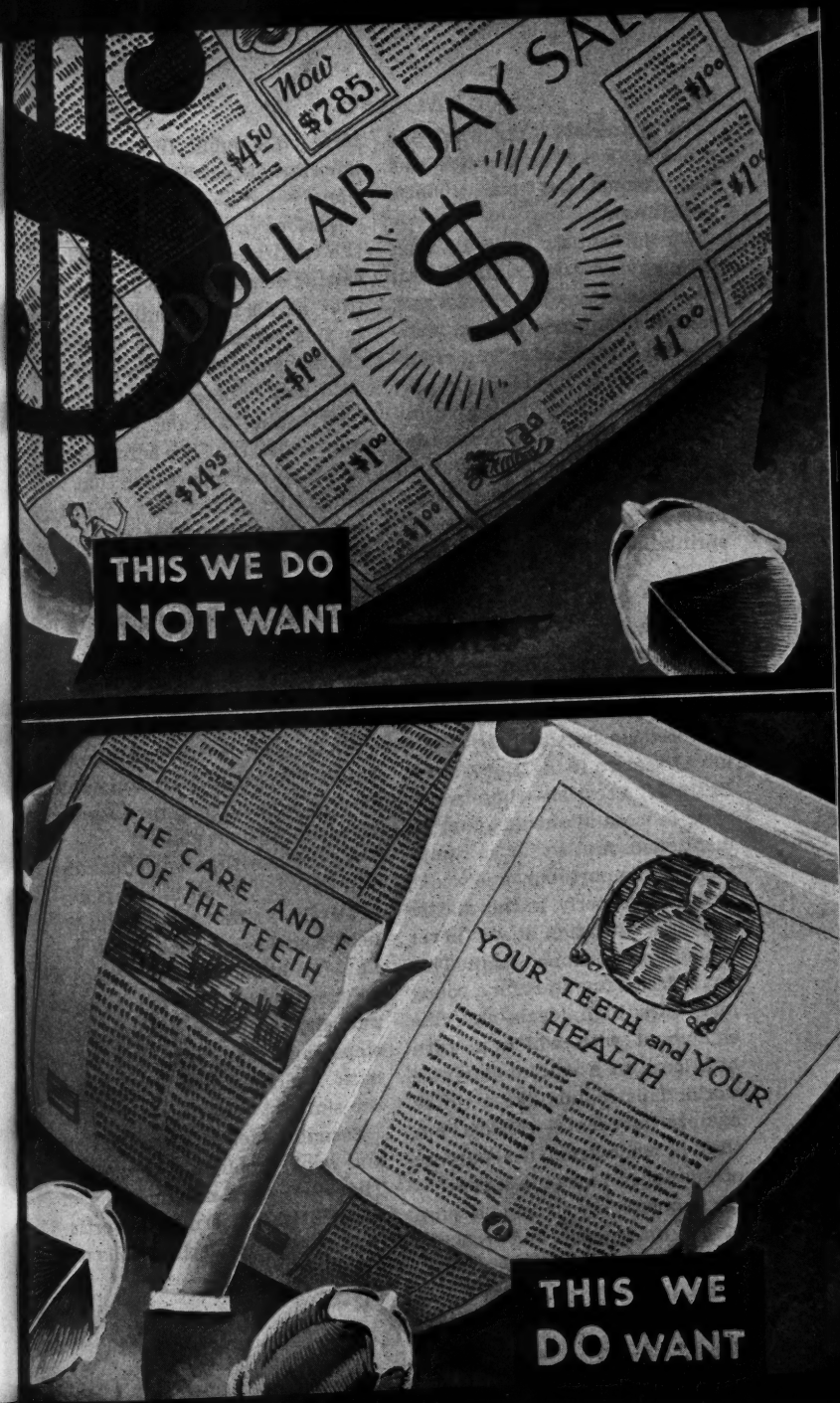
[1]Clapp, G. W.: Help Yourself to a Practice, Oral Hygiene 26A:1447 (November) 1936.


Now $785.
$4.50
$14.95
$1.00
THIS WE DO NOT WANT
THE CARE AND F OF THE TEETH
YOUR TEETH and YOUR HEALTH
THIS WE DO WANT

To appreciate fully what our problem is, let us consider our background and our public's background.

We as dentists have all been through the "mill," the dental school. And a mill it truly was, packed with processes and technicalities, together with a cramming into the heads of the neophytes a mass of dissociated information. The key to success depended on the student's ability to assimilate this heterogeneous mass together with a generous sprinkling of personality and luck!

Business Aspect Concealed

If one kept his ear to the ground, an occasional bit of information would trickle through to the effect that one had entered a profession by which he would have to earn a living. But Money! Business! Fees! sh—those words were taboo and should never be mentioned. And so far as equipment to impart our knowledge to others properly, in this matter of public education, it was never thought of, let alone taught. This was indeed a fine start for a young man with high ideals and fine equipment with which to turn him loose in a cold, dollar-wise world. This sounds like a tirade against our dental schools, but that is aside from the purpose of this paper. I am only endeavoring to create in your mind a sense of our inadequacy and inability to teach a public that is largely ignorant of facts on dental questions.

Various authorities establish the total number of persons receiving dental care at one-fourth, thus leaving ninety million people in this country yet to be made dental conscious. Only now, with such figures before you, can you even begin to realize the Herculean task that lies before us. It is of greatest importance that we obtain the good will, sympathy, and understanding of this vast number of people. To do so will require a well planned, far-reaching and dynamic program on a nation-wide scale.

There are many sides to this complex question. Much analysis has to be done before the work is even started. To start a program without proper preparation would be the same as sending an army to battle without guns.

To begin with, we as educators will have to become students, figuratively, in the first grade. We need a little education along the lines of public relations before we can intelligently follow up a publicity campaign. Our first steps must deal with the most basic fundamentals and follow the simplest routine.

Secondly, dentists are dentists and not publicity specialists. There has been no education of the dentist concerning advertising or publicity. Perhaps it is not

only enlightening but also necessary to analyze advertising to obtain a better understanding. Just as the public needs understanding of dental problems, so dentists need understanding of advertising problems in the field of dentistry.

Let us step down from the stage of dentistry and sit down in the audience with Mr. John Public. Now you see paraded before your eyes in the magazines and papers advertising from the lowliest form of notice or announcement to the large double-page colored ad. You listen to the radio and hear everything from the short electrical transcription to the world-wide hook-ups of symphony concerts. All this adds to your store of knowledge and enjoyment. You are being educated—to something—by somebody!

At the Sign of the Dollar

Remember we are still offstage. We are not dentists just now; we are the public. Let us pick up a newspaper and go through the advertising sections. We see the pictures and ads of automobiles. Somewhere in the display is the price, so many dollars. We see a large department store advertise a coming sale, a percentage off on everything in the store. The dollar sign again! We see a construction firm urge, "Build now! Prices are going up!" Again the dollar appeal. A fuel company urges the purchase of fuel before a scarcity may cause an increase in price. Again we meet the dollar; And somewhere in the advertising section we will meet Doctor Painless Pullem, "Plates at unheard of new low prices." Price—the dollar sign—known in advertising circles as commercial advertising.

For years this type of advertising has held the attention of the public—*you!* And when you think of advertising, immediately your thoughts turn to the dollar sign. This type of advertising has for its purpose the sale of merchandise now—and to be successful must produce immediate results. Advertising men judge the value of commercial advertising by the amount of goods sold. Often the main appeal in selling merchandise now is the price. Quality, guarantee, and other features are secondary, and used in commercial advertising as a build-up or prop for the price appeal.

Right now it is my opinion that commercial advertising for dentists is definitely out of the picture. In the past, when the subject of advertising in dentistry has been brought up, dentists with a background of commercial advertising have been right in frowning on such practices. Primarily, owing to the fact that each dentist is a business unit, advertising of price is impossible.

Secondly, owing to the nature of our work, advertising of price is irrelevant inasmuch as each case is different. We serve the public with service and not with merchandise.

The Service Appeal

Let us open up a national magazine with a large circulation. Look at the beautiful advertising displays. Note the simple and direct, yet forceful, messages of the huge industries. The United States Steel Corporation, the American Can Company, the large life insurance companies and countless others have a message for you about themselves. Have you seen the dollar sign in these ads? They are not selling merchandise direct to you now. They have something to give you besides merchandise. Through giving you a better understanding of their service and their motives, they expect to obtain your good will so that when your needs arise in their line you will think of them.

Service advertising! More and more industries and institutions in every field of endeavor are beginning to realize the importance and value of gaining the good will and understanding of the public. They want to make the public think more favorably of them.

You hear on the radio large concerns sponsoring programs for your entertainment and enjoyment. You think more kindly of them because they have brought you some moments of joy and pleasure. The Standard Oil Company, Henry Ford, General Motors, General Mills, Du Pont—we could name many others. All are striving to get you to think more kindly of them. Of course it follows that you will buy their products, but the basic reason in this type of advertising is that you buy the product because of the service offered, not because of the price. Don't you think that dentistry would fit into a picture of this kind? Isn't it time that we give the public something constructive to think about?

Advertising commands our attention! We know only what we read and hear. Our health, ethics, habits, and life itself are not only influenced but controlled by advertising or some form of publicity.

"Advertising is a tremendous force in the social and economic life of a people; it is a vital factor in the building up of any enterprise." These words by one of the leading writers of the business world, Bruce Barton, should stimulate in your mind questions concerning the future welfare of your business—your profession. Just think if the story of dentistry, properly presented, were in the parade!

"But," you say, "that is not for dentistry."

This has been the attitude of dentists for years. The American Dental Association openly stated that it "frowns" on paid publicity. Why? Have you yet heard a sound reason? Can it be that this antiquated idea persists among dentists because of misunderstanding or lack of knowledge on questions of public relations? There is great need for clarifying certain befuddled notions and inducing dentists to think along more broadminded channels.

Ethical Procedure

The code of ethics, which I firmly believe in and support, states that no dentist shall advertise as an inducement to patronage and the code goes on to list methods and means of not advertising. Take notice—it does not state *Dentistry* shall not advertise; it says *Dentists* shall not advertise. Therein is a world of difference in meaning. Immediately a different light is placed on a program of building public good will and understanding on a national scale. A nationwide program of publicity backed by dentistry, not dentists, is legitimate and ethical. Moreover, as a more complete service to our public, it becomes our duty and responsibility to institute such a program!

Now then, let us turn to the public's background. What real effort has been made by the dental profession to reach the whole public? None whatever! Occasionally we take time out to tell a patient in our office the story or some small part of the story of dentistry, particularly if we have time. Time lacking, the public goes out just as they came in, with the exception of a few plugged teeth and minus a few dollars.

The public have received bits of information through commercial advertising of toothpastes and mouth washes. The advertising dentist has for years poured out subtle, self-centered, commercial propaganda, that has created in the public mind an unfavorable picture of our profession. The jokesters and stage wise-crackers are always on the lookout for new derogatory jokes on the dentist. The press, in reporting dental news, often makes "mistakes." In social gatherings and on the street, people shudder at the mention of dentistry, and offer most sympathetic looks and remarks to those bound for the dental office.

Harmful Publicity

There are other important problems often present, upon which the public needs enlightenment. In the December fifth issue of *Liberty* magazine there appeared a most insidious editorial which struck at the very foundation of the healing arts—dentistry included. This poisoned barb dealing with socialized medicine

no doubt has reached millions of persons to whom it appealed as the strictest logic!

Little wonder that a public continually exposed to half-truths and false statements and to dollar-sign dentistry are totally ignorant of the vitally important facts concerning dentistry. True, it will take some time to correct or change this picture, years perhaps, but it will never change so long as we sit down and wish and wait for somebody to do something.

Again, let the futility of attempting to reach the public through our offices be emphasized. It cannot be done. Dentistry must resort to a nationwide program designed to reach all or most of the people. In the present order of things this can best be accomplished through service advertising. Perhaps you don't like the word "advertising." Call it publicity, education, or what you will, it is one and the same thing. It has to do directly with the public's background so far as dental education is concerned. When patients are in your office they are there to have pain relieved or a diseased condition corrected. They invariably have but two things on their mind, pain and cost. Under these circumstances any educational effort on your part in the office is either listened to with unhearing ears or completely nullified. Experience shows that the pain and the bill, particularly the latter, linger the longest in the patient's memory. Therefore, educational efforts should reach the patients or prospective patients when they are in a more receptive mood. Anything less than a nationwide program by organized dentistry will fail for two reasons: The majority will not be reached; and the public will not receive a uniform picture of dentistry that they need.

Until dentistry begins to function in a modern manner, the present stages of stagnation will soon lead to complete petrification under socialized dentistry. Then it will be too late! As soon as dentistry becomes a political football, it won't be in one position long enough to organize.

While it is still a profession, organized for the common welfare of both the public and the dentist, let us in the name of service to humanity enlighten the public so that when they are confronted with questions on public and oral health, *they will know something about it.*

210 *Rookery Building*
Spokane, Washington

EUROPEAN HEALTH INSURANCE

Its Organization and Administration

GENERAL COMMENTS ON FOREIGN SYSTEMS*

I. Tendencies in Health Insurance

1. ". . . health insurance in Europe has been moving steadily from voluntary to compulsory systems."
2. "In almost every country, which has had experience with a system of national or regional sickness insurance, there have been evident the following tendencies:
   a. "to place increasing emphasis upon *medical* rather than *cash* benefits, especially by providing medical service instead of furnishing cash with which to purchase the service;
   b. "to expand the variety of medical benefits;
   c. "to expand the population eligible to receive insurance medical benefit by covering the dependents of the insured persons;
   d. "to increase the active participation of the insurance system in measures concerned with the prevention of disease."

II. The Professions and Health Insurance

1. "Prior to the beginning of British health insurance (1911), the medical professions of many countries manifested little or no interest in the subject when their systems were first being established and the insurance programs were generally instituted without the adequate consultation or advice of these professions."
2. "European experience seems to show that the design of a health insurance system should be counselled by the professions but determined by representatives of the public. It is to the evident advantage of both groups that an even balance be kept between the interests of the professions and of the people who are to be served. Neither group should exploit the other."

III. Status of Present Systems

1. "So long as the contributions from the insured or from the insured and their employers are insubstantial by comparison with the ordinary medical expenditures of the well-to-do and the rich, insurance practice must remain a poor-man's practice."

IV. Results

1. "There can be no doubt that sickness insurance has contributed to improvement in the public health, though not as substantially as had been anticipated or predicted by advocates of the system."

V. European Attitude Toward Health Insurance

1. ". . . one of the unique characteristics of contributory health insurance and the one which attests most unequivocally to its beneficient function is that no country which has ever tried it has given it up."

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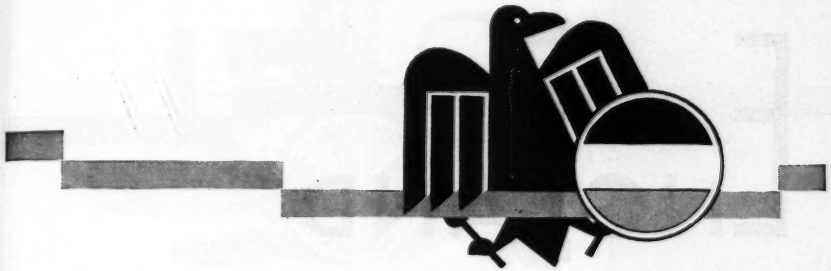
*Falk, I. S.: Security Against Sickness, A Study of Health Insurance, America's Next Problem in Social Security, Garden City, New York, Doubleday, Doran, and Company, Inc., Pages 59-263, 1936.

GERMANY

SYSTEM ESTABLISHED	ORGANIZATION AND ADMINISTRATION	INSURED PERSONS	CONTRIBUTIONS	MEDICAL PRACTITIONERS	COST OF INSURANCE
In 1883 by national compulsory sickness insurance law. Outgrowth of voluntary sickness insurance in existence since 1854. Oldest of large national schemes; supplied pattern for the systems which developed in many other countries.	Administrative responsibility for system rests primarily with the sickness insurance societies or funds (*Krankenkassen.*) Some of the societies are outgrowths of the mutual aid associations, institutions founded many years ago by local authorities, townships, proprietors of factories, guilds, trade unions, and similar groups; others are more modern organizations created for the specific purpose of serving as insurance societies. Control of sickness insurance fund has, in each case, been vested in a body of representatives, two-thirds of whom are elected by insured persons and one-third by the employers.	Only employed persons are required to be insured. Includes all manual workers, apprentices, domestic servants, and so on; salaried employees and officials in manual or non-manual work, who earn less than $858 a year. Gainfully occupied persons in certain other classes whose earnings exceed specified maximum, or self-employed persons may insure voluntarily. About two-thirds of the population or 36,700,000 persons were insured in 1934.	Employed persons pay from 1.5 to 6 per cent of basic daily wage (averaged 5.10 per cent in 1934). The insured person pays two-thirds; his employer pays one-third of the contributions. (Under law of July 5, 1934, contributions of employers and employees are to be equal—not yet in effect.) State makes no contributions except in providing supervision for operation of insurance societies (and except for its share of the government operated hospitals). Contributions are not uniform as in England; based on insured person's ability to pay.	Only qualified or licensed practitioners may be employed by the insurance societies. A free choice of physician among all who engage in insurance practice has been customary. This has been limited, however, by: a. restrictions in some large cities upon the number of physicians permitted to engage in insurance practice; b. the instances in which salaried physicians have been employed by local insurance authorities for service to insured persons. Physicians are remunerated: a. according to established fee schedules for services or b. by annual salary and annual per capita basis.	In 1933 medical services furnished to insured persons (including the costs of administration) cost $6.96 per person, and the more limited service furnished to dependents cost $3.50 per person.



CASH BENEFITS	MEDICAL BENEFITS	DENTAL BENEFITS (STATUTORY)	CHANGES IN INSURANCE LAW SINCE 1933	ATTITUDE OF PUBLIC AND PROFESSIONS TOWARD HEALTH INSURANCE
For disabling sickness: Cash benefits for disability must not be less than 50 per cent of basic daily wage, payable for duration of disabling sickness from the first day to the end of twenty-six weeks (may be increased by fund up to 75 per cent of basic wage.) Maternity benefits: Statutory cash benefit fund pays to an insured woman a lump-sum maternity benefit of 10 Rm.[1] and a daily benefit equal to cash sickness benefit (50 per cent of her wages) but not less than 0.50 Rm. per day for four weeks before and six weeks after confinement. Comment: ". . . provision of cash benefits offers an especially potent incentive to malingering and to the exaggeration of acute or chronic illnesses, especially among seasonal workers."[2]	Include: Service of general practitioners and specialists. Prescribed medicines, spectacles, and other minor medical or surgical appliances (insured person must pay a share of the cost). Hospital treatment when necessary. Medical attendance for members of insured person's family. Maternity care (obstetrical attendance and, if necessary, medical attendance and hospital treatment) for insured women and the wives and daughters of insured men. Scope and quality of service vary widely, especially as between the large cities and rural areas. Medical service, which was first provided as a supplementary benefit, has become the principal benefit and accounts for more than two-thirds (69 per cent) of the total expenditure made from insurance funds. Note: Basic medical benefits for insured persons have been expanded by recent legislation to embrace more or less complete medical service for them and their dependents.	Dental benefits include treatment of acute toothache; the extraction of bad teeth or roots; prophylactic treatments; dental surgery; and financial contributions toward the cost of artificial teeth when the need for a denture involves the general health of the patient. Of total expenditures for medical benefits, 6.7 per cent goes for dental service. Expenditure for dental care by all sickness funds was 75c per insured person and 28c per dependent for dental care in 1933. Benefits provide only a small fraction of adequate dental care and the expenditures are still only from 10 to 20 per cent of what would be needed to pay for adequate dentistry for the entire population.	Not yet effective: The contract for medical service will no longer be made between each *Krankenkasse* and the individual physician, but will be negotiated centrally between representatives of the medical organization. Payment for services will actually be administered by the medical society. These reforms are expected to end disputes between the funds and the professions over the equity of rates of remuneration and will permit establishment of fee schedules prepared by joint groups of equal standing. Instead of contributions being charged two-thirds to the insured person and one-third to the employer, the division is to be equal.	". . . with entirely minor exceptions, neither working men nor employers would have sickness insurance repealed."[2] "When sickness insurance was established, the professions had little or no interest in social insurance and took no active part in its design . . . In consequence, many unwise provisions were written into the laws and many undesirable practices were established by societies."[2] "Physicians, dentists, and other professional groups have decried the tendency of the societies to underpay and pauperize the practitioners. Inadequate remuneration per patient or per service compels a physician to earn his livelihood by undertaking a large volume of work and leads to overwork, and to hasty, superficial, and unscientific practice."[2] Note: "The German system makes the fundamental mistake of combining two entirely distinct functions of sickness insurance; namely, the work of the practicing physician and that of the examiner or inspector, on whose judgments cash benefits are awarded. The practitioner as a family doctor is seldom in a position to protect the carrier against the influence exerted by the patient . . ."[3]

[1] $2.38 in 1933.

[2] Falk, I.S.: Security Against Sickness, a Study of Health Insurance, Garden City, New York, Doubleday, Doran, and Company, Inc., Pages 120-140, 1936.

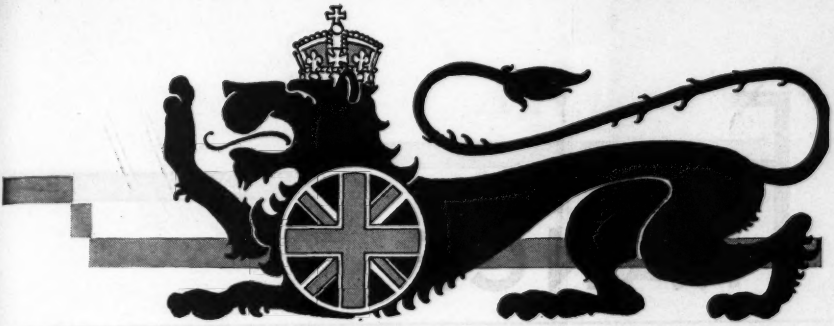
[3] Simons, A. M. and Sinai, Nathan: The Way of Health Insurance, Chicago, University of Chicago Press, Page 58, 1932.

ENGLAND

SYSTEM ESTABLISHED	ORGANIZATION AND ADMINISTRATION	INSURED PERSONS	CONTRIBUTIONS	MEDICAL PRACTITIONERS	
				REGISTRATION	RATE OF PAYMENT
Under National Insurance Act, 1911. Became effective in 1912. Compulsory-contributory type. Exception: Any person (other than a married woman) who has been insured for at least two years as an employed contributor and has paid at least 104 weekly contributions may continue as voluntary contributor, if he wishes, after ceasing to be employed.[4]	Before 1911, "friendly societies," the "benefit associations" of trade unions, and various insurance agencies provided sickness benefits to about one third of population. Under insurance system, these miscellaneous societies became "Approved Societies," not operated for profit, and controlled by Insurance Committees (one in each County composed of representatives of insured persons, local physicians, and representatives appointed by government.) Ministry of Health supervises entire organization of societies in England and Wales, also operates Regional Medical Staff since 1920 (about 80 whole-time salaried physicians available to examine insured persons to check abuses and to supervise and improve quality of medical care furnished.) Regional Dental Staff has been created to perform similar services with respect to dental care. Results: "The general death rate has fallen materially since the scheme was introduced and it is reasonable to attribute this in some measure to the medical and other benefits provided under the scheme."[4]	Includes only those in low-income groups All manual workers over 16 and non-manual workers who earn not more than $1,217. Dependents of insured persons not covered.	Workers, employers, and State share the cost. Weekly contributions are: Men—9c Women—8c Employer pays 9c per week for each man and woman. State pays: a. one-seventh of cost benefits and of *local* administration for men; one-fifth of these items for women. b. entire cost of central administration. Contributions do not vary with wages.	Every licensed physician who elects to do so may practice under the system by having his name entered on the panel. Insured persons have free choice of physicians on *local* panel. Insurance medical practice is conducted under regulations formulated by the Ministry of Health after consultation with representatives of the medical profession. Insurance practitioners have no direct relations with the approved societies, only with local insurance committees.	Physicians are paid a capitation fee of $2.19 per patient, per year. A practitioner working alone may not accept more than 2,500 insured persons. In 1934 the average number on a physician's list was 811. Insurance physicians earn, on an average, as much or more from private general or specialist practice as from insurance practice. "The insured person (who wishes to) is permitted to make his own arrangements for obtaining medical treatment, and may receive from the insurance committee a contribution toward the cost of his treatment. There were 36,700 who took advantage of this exception in 1928."[5]

[4]Encyclopedia Britannica 16:145-148

[5]Simons, A.M. and Sinai, Nathan: The Way of Health Insurance, Chicago, University of Chicago Press, Page 70, 1932.



CASH BENEFITS	MEDICAL BENEFITS	ADDITIONAL BENEFITS (NOT STATUTORY)	COST PER PERSON NUMBER INSURED	CHANGES RECOMMENDED
Cash sickness benefits begin with fourth day of disability for first illness; for subsequent ones, within 12 months, payment begins at once. Amount to 15s. ($3.65 per week for men; $2.92 a week for unmarried women; and $2.43 a week for married women, for a period not exceeding twenty-six weeks.) Disablement benefit: If disability continues longer than twenty-six weeks, the insured person becomes eligible to a weekly disablement benefit equal to one-half of sickness benefit. Maternity cash benefit: Is payable after forty-two weeks of membership and amounts to a lump sum of $19.47. Cash benefits and cost of providing them account for 62 per cent of the total expenditures; other benefits and cost of providing them represent 38 per cent of total. Note: These proportions are the reverse of those that obtain in German insurance practice. British emphasis is on cash benefits rather than medical care.	How funds are divided: Physician's services.....61.4% Drugs and appliances.....18.7% Dental services .....14.2% Eye care....3.4% Convalescent services.....0.8% Hospital services .....0.7% Other services .....0.8% --- Medical benefits include all necessary care by general practitioner (not services of specialist) in his office or patient's home, and such drugs and appliances as physician considers necessary. Medical benefits are not extended to insured person's family. Furnished to all employed contributors and to all voluntary contributors except those who earn more than $1,217 a year. (Contributions of voluntary contributors not eligible to medical benefit are therefore reduced by six cents a week.)	When finances permit, insurance funds may supply additional benefits, such as dental and ophthalmic treatment (cash benefits); increased cash (sickness and disablement) benefits; and sometimes special grants of funds to meet the cost of hospital or other institutional treatment. Dental benefits—most popular and extensive additional benefits.[4] a. 5000 administrative units of Approved Societies with 9,800,000 members furnish dental (cash) treatment benefit. b. total expenditures (of insurance funds only) on dental benefit in England and Wales were $10,248,000 in 1931, equivalent to $1.05 per person eligible to receive this benefit. Adding the part paid by the insured person, the cost per person would be $1.75 per year. c. the insured person pays portion of cost of treatment; Society pays not less than one-half (if cost is less than $2.43, Society must pay all). d. in practice, Societies pay about 50 per cent of cost of dentures and about 75 per cent of the cost of treatment; the remainder is paid by insured person.[4] e. private bargaining between dentist and patient is forbidden—insured person applies to his Society for a "dental letter"; may present it to any licensed dentist, who will be remunerated jointly by Society and patient according to scale of fees prescribed by Dental Benefit Regulations.	Total cost of health insurance (expenditure) per person was $11.38 in 1933 (for medical and cash benefits). --- In 1934-35 expenditure for all insurance medical benefits was $3.96 per person; statutory medical benefits only $2.78 per person. --- State annually pays from 15 to 17 per cent of insurance costs from tax funds. --- 18,360,200 persons were insured in 1935; 40 per cent of entire population and 80 per cent of gainfully employed.	British Medical Association recommends: Enlarging scope of medical benefits to include specialist treatment, dental service, institutional care, and so on. Including dependents of insured persons. Consolidating administration of insurance medicine with other medical bodies (public health, poor law, hospital services). --- The Royal Commission on National Health Insurance recommends "divorcing the medical service entirely from the insurance system and recognising it along with all other public health activities as a service to be supported from the general public funds."

FRANCE

SYSTEM ESTABLISHED	ORGANIZATION AND ADMINISTRATION	INSURED PERSONS	CONTRIBUTIONS	MEDICAL PRACTITIONERS	CASH AND MEDICAL BENEFITS
Compulsory insurance law against "the hazards of sickness, maternity, invalidity, old age, and death adopted April 30, 1930." Law was outgrowth of experience with voluntary insurance which received legal status by the law of July 15, 1850.	Plan operates under the control of the Ministries of Labor and Finance and the (consultative) Superior Council of Social Insurance. In each *department*, insurance is administered by *services regionaux*, and under these by primary insurance funds (*caisses primaires*). Insured persons associated for geographical, occupational, or social reasons may combine for the creation of a *caisse*, subject to provisions laid down in the law and in the ministerial decrees.	Include all employed workers of both sexes, between ages of 13 and 60, whose income is less than $1000 for those who live in the country or have no children. In large cities the limit is 18,000 francs.[6] It increases for each of first two dependent children; the maximum for larger families is fixed at 25,000 francs. [6] $828 at current exchange rates.	Divided equally in commerce and industry between employers and employees and vary according to size of wages earned; amount to 10 per cent of basic wage.	Any physician may attend insured persons whether or not he has agreed to the contract entered into by the medical association and the fund to which the insured person belongs. Patient has completely free choice of physician and he may change his physician whenever he wishes to do so. Insurance funds do not remunerate the physician, dentist, or hospital. The patient pays his own bills and is reimbursed by his insurance fund up to 80 per cent of agreed standard rates for specified types of service. This type of arrangement applies to services furnished by general practitioners, dentists, surgeons, other specialists, midwives, or hospitals, and to the costs of medicines and appliances prescribed by a physician.	Insured person is eligible to cash or medical benefits only after at least sixty daily contributions have been made to his account during three months preceding illness. Cash benefits in industrial and agricultural schemes differ: a. in agriculture the cash benefits for sickness, maternity, and death are, like the contributions, fixed irrespective of wages. b. in industry and commerce cash benefits vary according to the wage class to which the insured person belongs. c. cash benefit (for loss of wages) is fixed at 50 per cent of wages. --- Medical benefits are more similar to German than English in scope: Embrace treatment for insured person, his wife, and his children who are under 16 and who are not gainfully employed, for all illnesses, and from the beginning of such illnesses. Complete medical, surgical, and preventive treatment, and medicines and appliances are covered for six months in any one illness; that is, the patient is insured against part of the cost of such treatment.

COST OF HEALTH INSURANCE	PRINCIPLES DICTATED BY PROFESSIONS	DEFECTS OF SYSTEM	ADVANTAGES OF SYSTEM
All sickness insurance benefits combined cost $4.64 per person in 1932. Forty per cent ($1.87 per insured person) was spent for cash benefits; 60 per cent ($2.77 per insured person) for medical benefits. This represents only expenditures made by the *caisses* and is only about 80 per cent of the expenditures authorized. Dental service accounts for 5.37 per cent of the total expenditures.	Freedom of every licensed practitioner to undertake the treatment of insured persons and their dependents. Free choice of physician by the insured. Freedom in the prescription of medicines. Payment of the physician by the insured. Payment according to terms of medical act. Preservation of privileged communication. Discipline of physicians by the profession.	Patient pays substantial part of medical costs; frequent illnesses still mean a financial burden. Conjunction of medical and cash benefits encourages malingering. While plan has helped to entrench private practice, it has led to more extensive supervision over that practice. In Paris about 50 per cent of cases are investigated, and in about 60 per cent of these the patient is examined by the physicians of the *caisse* to check on the record. The French physicians have brought about stringent limitation of fees, a complex and cumbersome fee schedule, necessity for close administrative supervision, conflicts with insurance authorities, and considerable loss in public esteem. Fee-for-service payment, some believe, restricts preventive practice and encourages excessive treatment even beyond that which normally occurs in non-insurance practice because the person is guaranteed reimbursement.	The French health professions have been partly relieved from the burden of unpaid service for the poor. The fear of sickness costs has been partly lifted from many persons of moderate means; and a new though limited opportunity has been provided both for lay and professional groups to increase both the volume and quality of medical services. Some leaders of the professions have taken a strong stand to improve professional services and to encourage interest in preventive medicine. Note: "All European experience testifies that the professions should have a strong and authoritative voice in the design and arrangements under which they must serve. The French experience, though comparatively short, nevertheless makes it clear that the strength of the professional voice should not exceed proper and reasonable bounds."—I. S. Falk.

A New Order in
DENTAL ETHICS

by S. JOSEPH BREGSTEIN, D.D.S.

WHEN THE CURTAIN of life was slowly unfolding upon civilization, man began to recognize the existence of disease and the phenomenon of death.

Groping about in sheer amazement, he attributed the unexplainable to "Forces."

The Greeks had their own philosophies of medicine and Asclepius was created to be their god of healing.

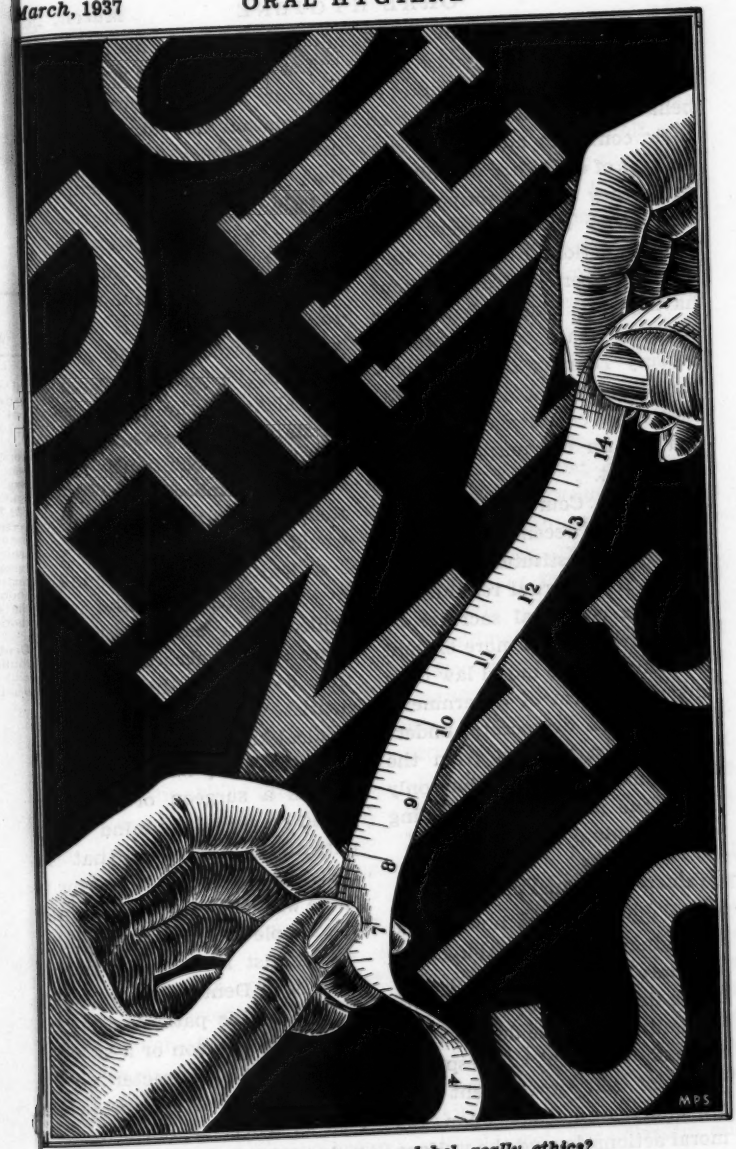
About the sixth century B. C., rational medicine first took form among the temple physicians who were known as the Asklepiads. They consecrated their lives to a better comprehension of the physical ills of their fellowmen, and adopted certain ethical regulations based upon the Greek philosophic conception of morality. They took an oath not to divulge the secrets of their profession, to offer appreciation to their gods, and to practice their calling ever mindful of a sharp differentiation between good and evil.

The pledge of medicine or the "Hippocratic Oath" took its form from the followers of Asclepius. Osler significantly states, "Could Hippocrates meet again a class of students at some modern Cos, and discuss the changes which twenty-five centuries have wrought, he would repeat again those noble words which have found in this triumph their professional realization: To serve the art of medicine as it should be served, one must love his fellowmen."

Dentistry emerging from the status of the craftsman evolved into a position where the work of the artisan was no longer of consequence, unless it was based upon the knowledge of biology, the physiology, and pathology of tissues.

The line which at one time separated dentistry from medicine became obscured by the harmonious embrace of interrelated subjects and the development of a oneness of purpose between physicians and dentists in their efforts to alleviate and prevent human sufferings.

The Hippocratic oath was the foundation of the medical code of ethics and is still in use. The dental profession, which devel-



Is all this, which we so label, really ethics?

oped later than medicine, based its concepts of morals and ethical practice upon those principles of behavior procedures to which their confreres adhered.

Codes of ethics are worth while when they have a purpose and when they actually accomplish their function. But when they become a series of admonitions having no more significance than so many paragraphs of nursery rhymes, it is in complete order for a dignified profession to commence a critical analysis for the purpose of improvement.

Supreme Court Justice Louis D. Brandeis recently said, "Democracy substitutes self restraint for external restraint. It demands continual sacrifice by the individual and more exigent obedience to the moral law than any other form of government. Success in a democratic undertaking must proceed from the individual. It is possible only when the process of perfecting the individual is pursued."

Evaluate Code of Ethics

We must attempt now in the changing order of things to evaluate our present code of ethics so that it too will have greater significance. The dentist must be made to accept the responsibility of self government and to understand that upon his moral actions depend the welfare of the public and his profession.

Let us dissect the code of ethics of the American Dental Association and study some of its philosophies, which tradition has complacently adopted.

Lest this be characterized as heresy, we wish to state at the outset that a still small voice within us demands an answer to the question: "Is all this which we so label really ethics?"

Section 1 of the American Dental Association Code of Ethics states that the "Golden Rule" should be conscientiously applied by every member of the association, "Do unto others as you would have others do unto you."

A dentist who is not qualified to extract teeth or who is unskilled as a surgeon, has the same status (according to Section 3) as the highly skilled dentist with a background of medical knowledge. That section states that any listing of a dentist as a surgeon or specialist would create in the mind of the patient the impression that the individual so listed is superior to those whose names appear under the simple heading "Dentist."

A dentist receives the degree "Doctor of Dental Surgery." Yet, if he tells his patients that he is a dental surgeon or a surgeon dentist, he is characterized by the upholders of an antiquated code as "a deceiver of the public," and one who "casts blots on the

honor and dignity of the dental profession."

Defines Duties

Nevertheless, this code of ethics claims that it is created for the purpose of clearly defining the duties and obligations of the dental profession toward their patients and to apply the rule "Do unto others." Section 12 states that dentists should be ever ready to counsel the public on subjects relating to dental health service.

This section of the code further admonishes us to refrain from any act which may reflect upon the dignity of the dental profession, being ever mindful that a well merited reputation for honesty and professional ability carry with them their own reward.

How can we be honest with the public when we are forced to subjugate individual merit and place the skilled practitioner in the same class as the dentist who does not perfect himself to render the highest possible type of service?

Let us take a hypothetical case:

Doctor A. is an active member of his state society. He is a thorough student, takes postgraduate courses in dentistry every year, and reads at least four recognized dental journals. He is a member of a research group endeavoring to determine causes of dental caries.

Doctor B. does not belong to any dental society. He reads racing forms and plays golf with the aldermen. During the twenty years of his practice he took one course in dental economics and high pressure salesmanship. He refers all his extraction and surgery cases to a specialist who returns part of the collected fee.

If a patient of Doctor A.'s tells him that her grandmother's aunt was about to go to Doctor B. and what did he think of him as a progressive dentist and as an oral surgeon, Doctor A. would be highly unethical (in terms of the American Dental Association Code of Ethics) if he told the truth.

Grandma's Aunt finally went to Doctor B. and because the dentist was more keenly interested in the three year old at the fifth race than in the reaction of phenol on her gum tissues, she one day found herself minus a few more teeth.

Was Doctor A. really ethical when he refrained from telling what he knew and thereby possibly preventing the Aunt from receiving unskilled care? Did he really live up to Section 12 of our sanctified code which tells him that he must counsel the public on subjects relating to dental health service?

Would not the dignity and

honor of the dental profession be better upheld, its standards exalted, and its sphere of usefulness extended if we were to be franker with the people whom we serve?

We could tell them that all dentists at graduation are created equal, but that after years of practice they become unequal.

We could tell them that some dentists do not study, do not improve themselves, and are not, therefore, as qualified as those who by virtue of constant training, vision, and application of work are considered better dentists.

We could tell them that all is not gold that glitters and neither does the profession sponsor the glitter of painless panaceas, which are occasionally advertised even by recognized institutions. We could tell them that this too is unethical and unprofessional.

In no country of the world is ethics as much talked about as in our own United States. Most dentists throughout the universe follow an unwritten code of behavior based upon an appreciation of right consideration for the happiness of their fellow men.

Those who are possessed with vision and profound understanding of human relationships do not concern themselves with calling "Surgeon Dentists" names and extolling the "D.D.S.," regardless of his contributions to the service of mankind.

Startling as this assertion may seem, I believe that if the present code of ethics went into oblivion, we as the servants of our patients would be in a better position to create a higher type of ethics than now exists.

The scourge of dental caries affects poor and rich, farmer and industrialist, prince and beggar alike. Most diseases have received recognition from government administrations and constructive tangible efforts have been devised to cope with them.

Pasteur was accorded all the honors of France for his great discoveries in the elimination of hydrophobia and anthrax.

Dental caries, a more prevalent scourge than any disease since the dawn of civilization, still remains the same as it did during the days of Caesar. Primitive man had caries; the shepherds of Bethlehem probably suffered pangs of pain in decayed teeth.

Modern man with his radio, photo-electric cell, and China Clipper also suffers the ravages of this ancient disease.

Government Aid

Could there be a more ethical service to humanity than a coordinated sponsorship on the part of the dental profession to demand government funds for research to determine causes and

possibility for eradication of dental caries?

In a study made of the report of the department of health of the State of New York (1935) concerning their activities, only once is reference made to dentistry.

"The Division sponsored an additional feature at the State Fair in cooperation with the Good Teeth Council. Three times daily in the lecture room of the State Grange Building, an educational entertainer known as "Orenda, the Tooth Magician," dramatically related the essential steps necessary in the care of the teeth."

Think of it! The twentieth century in full progress with actuarial reports showing the United States leading the world in health, while dentists take little or no part in dental education or research for the benefit of humanity.

Is it ethical for a whole profession *en masse* to "let George do it" when it comes to public welfare? Haven't we outgrown the age of mysticism when magicians were engaged to arouse the public's interest in their health?

A profession whose prime purpose is service to humanity ought in deference to all that is embodied in the philosophy of ethical precepts endeavor to "render unto Caesar those things that are Caesar's." The practice of dentistry belongs within the confines of dental and not industrial jurisdiction. Employees by the thousands are conscripted by "benevolent organizations" into mutual insurance plans sponsored by utility companies, oil companies, and many other economic groups.

Debate on Ethics

Dentists meanwhile debate the "ethics" of signs in their office windows and are profoundly concerned with those few unfortunate misguided colleagues who employ circus publicity stunts to attract patients.

They overlook the fact that, in the interim, industrial philanthropists are establishing large dental clinics, department stores are giving low cost dental service to their employees, and some colleges sell wholesale dentistry to the masses.

The pay clinic situation in our country is appalling. No industry on the face of the earth would sit by with such lack of unified effort and permit outside forces to command and control them.

Surely the medical profession, whose code of professional morals we emulate, did not allow the continuance of industrial clinics, for example, for the benefit of compensation patients. The public now have free choice of their own physicians instead

of being obliged to accept the paid doctors of insurance companies.

The medical profession actually put into practice "A profession has as its prime object the services it can render to humanity." They protected the public, their patients, in a matter which they believed was for the best interests of their health.

While many dentists are taking courses in psychology under the misnomer of "dental economics," their confreres spend sleepless nights pondering over the problems of real dental economics which can never be divorced from ethics.

What are we doing of a concrete nature to protect our patients from the evils of pay clinics?

What are we doing in the nature of dental education to awaken the public to a realization that health is theirs for the asking?

Doctor Boyd S. Gardner, Dental Director of the Mayo Clinic, has suggested on many occasions a plan for dental inspection as a requisite for life insurance examinations. Have we as a profession made any concerted studies to effect this desirable link between the public and ourselves?

Accomplishment of noble purposes is not only ethical but a requirement, a compensation which we owe to society for the privilege afforded us to minister to their health.

We must believe as did Maimonides, the great physician, that we have been elected to watch over the health and life of human beings.

When dentists feel every emotion within them proclaiming that dentistry embodies their ideals in life, then only can they be honest with themselves and appreciate fully the significance of the philosophy of ethics.

We must develop the capacity to see in any given situation those essentials best adapted to elicit appropriate attitudes. Our conduct shapes itself according to the amount of conscious control exerted in equilibrizing our position in society.

There is no court of appeal above established ideals from which moral concepts are evolved. Such ethics makes its appeal to the "ought" in our behavior and that in itself implies obligation and duty.

It is not Utopian to ask in this momentous epoch that we adopt an attitude of expanding awareness toward fuller appreciation of ethics in dentistry.

We have so much work ahead of us that we ought not take one moment of life's precious time to quibble about irrelevancies.

Suppose a few men throughout the country want to call

themselves "Surgeon Dentists" and use signs of eight inch height instead of two by fours—what of it?

Is it not more reasonable to expect that, under the guidance of enlightenment and accomplished results, the public will eventually join our ranks in thought when we as a whole profession serve them truthfully and thereby ethically?

Recently more than five hundred representatives from thirty-three states heard the Assistant Secretary of the Treasury in charge of Public Health Service read the promise of President Roosevelt to give Federal help and sustained personal interest to the eradication of venereal diseases.

There is available, through the Social Security Act, 8 million dollars to carry out extensive plans to rid the nation of syphilis and gonorrhea, yet these diseases are, by no means, as widespread as dental lesions.

While we are on the subject of ethics would we not be rendering an invaluable service to our patients if we, the dental profession, were to strive for admittance into that division of our government which gives funds for the purposes of social security?

When we judge the true nature of ethics evaluating such documents as the American Dental Association Code of Ethics, we must consider ethics in terms of the relative place it occupies in human endeavour and the magnitude of its objects and the results it achieves.

If it becomes an instrument which is used to interpret in terms of bigness a reference to signs on the dental office door, then it has failed miserably in its purpose.

If it presents to us a definition of an ideal which our leaders put into actual application, then those ethical principles become at once elevated to a position of importance.

Dental ethics must have something inherent, real and tangible, to offer to society as its contribution to the permanence of the social structure.

7825 *Fourth Avenue*
Brooklyn, New York

ANNUAL INDEX AVAILABLE

The annual index covering the 1936 volume of ORAL HYGIENE is now ready. You may obtain a copy gratis by writing to the Publication Office, ORAL HYGIENE, 1005 Liberty Avenue, Pittsburgh, Pennsylvania.

Exploring PATIENTS' *Minds*

Anyone who reads the detailed and specific answers developed by this patient survey can improve his presentation of dentistry.

WHEN A PATIENT sits in the dental chair how often have you wondered what is going on in his mind? What does he expect from dentistry? What evaluation does he place on your services? To answer some of these questions the editorial staff of ORAL HYGIENE PUBLICATIONS explored the minds of 1200 dental patients in the attempt to discover what patients think about dentistry. The first installment of the report describing the results of this survey was published in the January issue of THE DENTAL DIGEST. The February issue carried another installment and the March and April issues will continue the series.

In the March number of THE DENTAL DIGEST the answers to these three pertinent questions are given:

1. How long do you expect dental work that has been done (fillings, bridges, for instance) to last?

2. What relation do the teeth have to general health?

3. Do you think of the extraction of a tooth in the same way as you do of an operation?

By their answers patients expressed the opinion that dentistry should last for a long period. It appears that they have too literally accepted our expressions "permanent" and "fixed," and believe that dentistry can defy the laws of mechanics and dynamics and last a lifetime. Although people are conditioned to believe in models and styles and improvements in mechanical and material things, they have not accepted the idea of change and modernity in dental restorations and appliances. This is not the fault of the public, but an expression of the weakness of dentistry in telling its true story.

People do believe that dental disease has some relationship to general disease. They are ready to accept the health story. They see three aspects of dental disease: that it can cause ill health; that loss of teeth and the consequent functional loss can im-

pair health; that general ill health can cause dental disease. Anyone who reads the detailed and specific answers to this question as published in the March issue of THE DENTAL DIGEST can improve his presentation of dentistry. It will help him anticipate his patients' attitudes.

Are not dentists too casual about tooth extraction? Don't we use the terms "simple" and "easy" extraction? Isn't it true that we treat tooth removal in an offhand manner as an extremely minor procedure? Do we dentists consider it a form of surgery? Patients have accepted our casualness, and now feel that the procedure is relatively unimportant. The majority of patients *do not* think of an extraction as a surgical operation. As one reply suggests, they consider it a painful necessity but only "a flesh wound."

Whose fault is it that patients have this attitude? Answer: Dentists!

The implications in the installment published in March DENTAL DIGEST are many. The three most important are: Even by inference we should not guarantee dentistry or suggest how long it will last. We should make more of an effort to tell the health story. We should treat tooth extraction with the importance and seriousness that it deserves.

DENTAL MEETING DATES

St. Louis University Dental Alumni Association, annual reunion, March 31-April 1, at School of Dentistry.

Alabama State Dental Association, sixty-eighth annual meeting, Battle House Hotel, Mobile, April 12-14.

American Society of Orthodontists, thirty-fifth annual meeting, Edgewater Beach Hotel, Chicago, April 19-22.

North Carolina Dental Society, sixty-third annual meeting, Carolina Hotel, Pinehurst, May 3-5.

Cleveland Dental Society, sixth annual two-day clinic, May 3-4.

Dental Society of the State of New York, sixty-ninth annual meeting, Waldorf-Astoria, New York City, May 4-7.

Pennsylvania State Dental Society, sixty-ninth annual meeting, William Penn Hotel, Pittsburgh, May 4-6.

Tennessee State Dental Association, seventieth annual meeting, Knoxville, May 10-13.

Illinois Dental Society, seventy-third annual meeting, Springfield, May 11-13, 1937.

Georgia Dental Association, sixty-ninth annual meeting, DeSoto Hotel, Savannah, May 17-19.

The Great Swampscott Convention, New Ocean House, Swampscott, Massachusetts, June 7-9.

American Dental Society of Europe, annual meeting, Paris, France, August 2-5.

KEEP YOUR OFFICE CLEAN

by A DENTIST'S WIFE

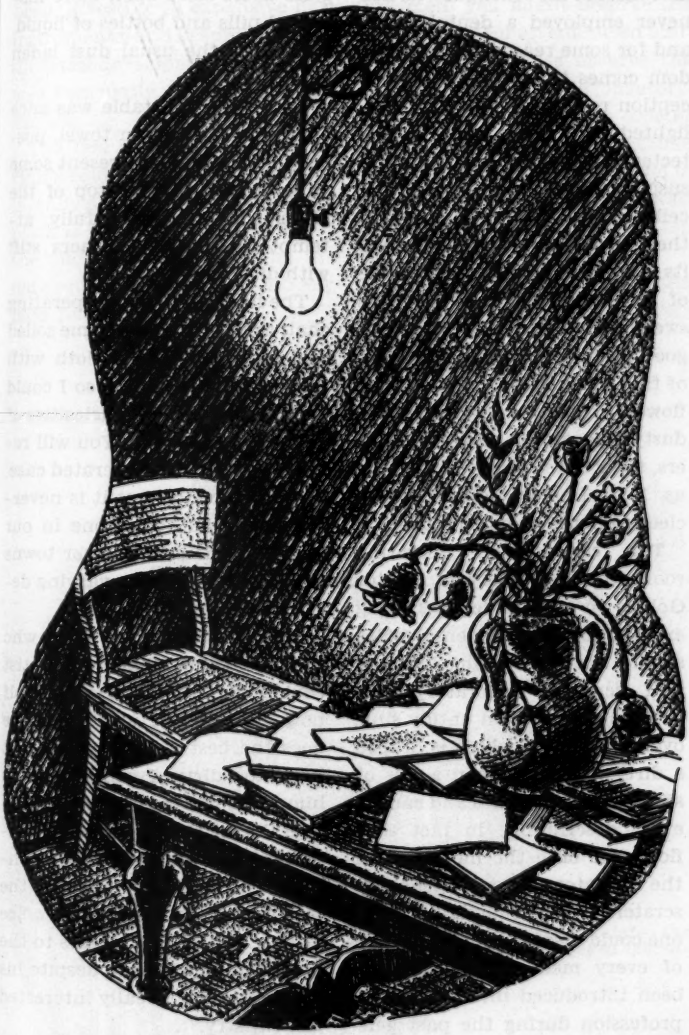
WHEN YOU WALK into the office of Doctor Flowers on a September afternoon it is readily seen that his hobby is gardening. On his library table is a bowl of tea roses and on his desk a bouquet of dahlias. On looking closer, however, you discover that flower arrangement is not his hobby; likewise, you surmise that Mrs. Flowers has been detained from the office today. For the unimaginatively arranged flowers are now in the bedraggled state reminiscent of cemetery jars, and in the ash tray are a few dead leaves and blossoms hastily picked off by Doctor Flowers. He has forgotten the morning reminder of his wife that what is carried in must also be carried out.

If Doctor Flowers boasted an assistant, seeing that the bouquets were kept fresh looking would be one of her first duties each day. She would also place in an orderly pile the bulb catalogs which Doctor Flowers has been glancing through between patients, for in their present state they are more indicative of a tendency to disorder than an interest in spring blossoms.

But Doctor Flowers, like most dentists in small towns, cannot afford to add the salary of a dental nurse to an already too heavy overhead. He must rely on himself, on an occasional visit by his wife, and on the semi-weekly cleanings of the scrub woman to keep his office in order.

Now scrub women are notorious for seeing only the middle of a room, but after all it is such little things as the head rest covers, the porcelain, the corner behind the water pipes, and the crack between the base of the operating chair and the rubber mat, that indicate the real condition of the office. These trifles speak louder than fine furniture in the reception room.

If a dental nurse is employed, her vigilance for the cracks and corners should be ceaseless. If the dentist works alone, he must be just as unrelenting in his quest for a sanitary office. For an insanitary office can ruin a practice just as rapidly as a lack of ability.



"Cluttering an otherwise good looking table are a bouquet of faded and dust laden artificial flowers and an assortment of dusty magazines . . . "

Take the case of Doctor Golf. Like most of his colleagues, he has never employed a dental nurse and for some reason his wife seldom comes to the office. His reception room is a dismal corner, lighted by a single bulb, unprotected by a shade of any kind and suspended from the center of the ceiling by a crude drop cord. On the floor lies a worn linoleum rug, its borders edged with a thin line of grit, the result of careless sweeping. Cluttering an otherwise good looking table are a bouquet of faded and dust laden artificial flowers, and an assortment of dusty magazines and travel folders, their dates going back as far as 1932. Doctor Golf evidently cleaned house about that time.

The combination operating room and laboratory of Doctor Golf is an even more interesting example of what a dental office should not be. Looking into the half screened laboratory, one catches a view of an untidy sink, over the edge of which is draped a dirty mop rag. Upon a tier of shelves repose bottles and cans of every description; in fact they flow over onto the metal top of the radiator. If one wished to scratch the accumulated dust, one could discern there the name of every medicament that has been introduced into the dental profession during the past generation.

In the operating room itself is another bookcase whose smoky glass doors close upon more historical pills and bottles of liquid, as well as the usual dust laden medical books.

An instrument table was once covered with a clean towel, possibly about 1934. At present some paper towels laid on top of the cloth towel unsuccessfully attempt to hide the corners stiff with dirt.

The head rests of the operating chair are covered with some soiled and greasy scraps of cloth with unhemmed edges. And so I could go on describing the curiosities of this dental museum. You will remark this is an exaggerated case, and so it sounds, but it is nevertheless an authentic one in our town, and doubtless other towns can produce offices in varying degrees of insanitation.

My neighbor Mrs. Tidy who used to think that no dentist could compare with Doctor Golf now confesses "I still think he does the best work in town, but he is too dirty. I will not go to him." His colleagues who recognize Doctor Golf as a man of superior knowledge say, "His extensive real estate holdings and the fact that he daily closes his office at four o'clock and repairs to the golf course show that, despite his ability, he is not really interested in dentistry."

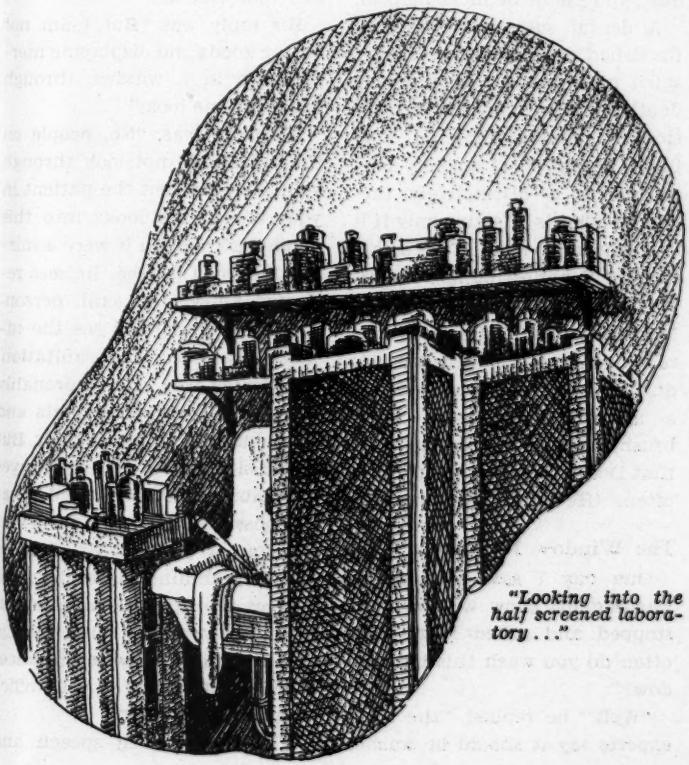
If this is true, why has Doctor Golf bothered to practice at all,

maintaining a considerable overhead, investing in expensive new instruments, and keeping up with the latest developments in dentistry? Personally, I think he is just careless.

The fact that much of Doctor Golf's equipment dates from 1907 is really not pertinent. In the next block is young Doctor Bowling of the class of 1930, whose up-to-date equipment is not yet entirely paid for.

When you step into his operating room you might observe the recent model of an enameled unit, but you might also observe the scummy ring in the lavatory. While wondering where Doctor Bowling keeps his can of kitchen cleanser, your eye might travel to a heap of damp and mussy towels which obscures the chromium top of an expensive sterilizer.

A blood stained cuspidor and some ugly looking roots strewn



"Looking into the half screened laboratory . . ."

on the rubber tile floor indicate that Doctor Bowling has had a crowded afternoon and, in his zeal to keep you from longer waiting, has not taken time to clean up after his last patient.

And as you turn around you might easily be tempted to toss a handful of crumpled notes onto the littered top of his new desk, now serving as a catch-all. If with your finger, however, you would trace some advice in the dust, you might be more helpful.

A dental suite equipped and furnished in the contemporary spirit may reflect contemporary dentistry, but if it shows signs of slovenly housekeeping, it may just as easily reflect slovenly dentistry. For a distinctively furnished office is effective only if it is clean and neat. The smart looking Venetian blinds, for instance, lose their smartness when laden with dirt. If Mrs. Housefurnishings deems it necessary to dust her blinds twice a week with a specially constructed triple brush, it is even more imperative that Doctor Bowling clean his as often. (He does not, however).

The Window Problem

One day I saw Mr. Jeweler washing his show window, so I stopped and asked him, "How often do you wash this big window?"

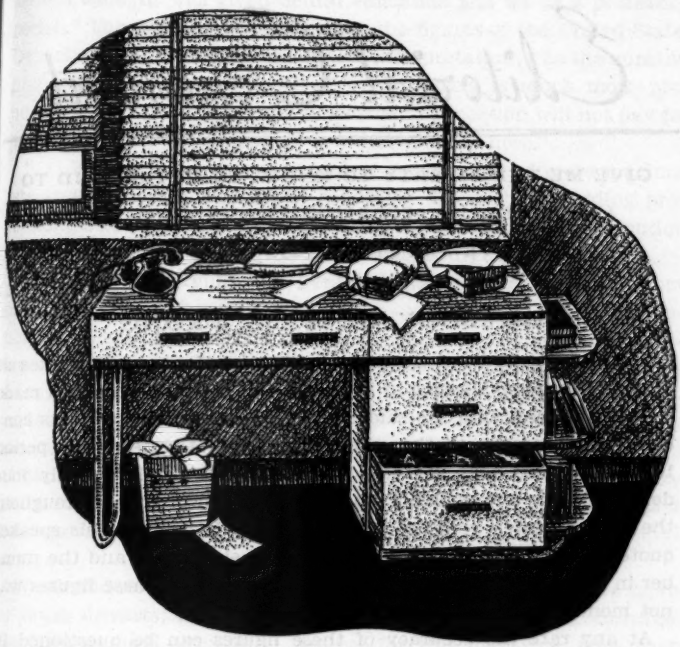
"Well," he replied, "the retail experts say it should be washed once daily, but I confess I do not get around to the job oftener than twice a week."

So I promptly betook myself upstairs to the office of Doctor Billiards (who you may guess is my husband). At that very moment Doctor Billiards' windows had not been washed for four months, and although the sun was shining brightly, it was a dreary day inside his rooms. I repeated to him what Mr. Jeweler had told me.

His reply was "But I am not selling goods and displaying merchandise in a window through which people look."

My reply was, "No, people on the outside do not look through your windows, but the patient in your chair here looks into this window as though it were a mirror, at you, a dentist. He sees reflected knowledge, skill, personality, and he should see the utmost cleanliness and sanitation. He cannot see you thoroughly sterilizing your instruments and manicuring your finger nails. But as he sits in this chair, his eyes rove about the room, and what he observes helps to form his opinion of you. If Mr. Jeweler thinks a shining plate glass enhances the attractiveness of his shop, do you not think that a clean window likewise enhances the attractiveness of your office and your services?"

This was a long speech and



" . . . the littered top of his new desk now serving as a catchall."

Doctor Billiards still seemed dubious, but anyway he promised to have his windows washed the next morning. So I hastened to suggest that he use ammonia or one of the new dustless cleaners instead of the time honored white powder. This latter does a good job of polishing, but leaves a heavy white dust which merely adds to an already discouraging cleaning problem.

And Doctor Billiards' problem is a discouraging one, in fact it is almost burdensome, but it is not hopeless. Witness Mr. Jeweler who occupies the space beneath. True he does not have the pumice and other dust resultant from the polishing of dentures and various laboratory procedures, but the three belching smoke stacks across the street pour as much soot into his store as into Doctor Billiards' office. His radiators create just as much grime and his open doors admit even more street dust. But this never ending dirt does not deter him from daily dusting his wares and polishing

(*Continued on page* 349)

Editorial Comment

GIVE ME THE LIBERTY TO KNOW, TO UTTER, AND TO ARGUE FREELY ACCORDING TO MY CONSCIENCE ABOVE ALL LIBERTIES. *John Milton*

SOMEBODY MUST BE WRONG

A DENTAL COLLEGE dean[1] speaking before the House of Delegates at the San Francisco Meeting of the American Dental Association made a startling prediction. He said that, if the number of dentists continued to decrease at the rate indicated in the ten year period 1922-32, in sixty-four years or 2000 A.D. there would be only four dentists in the city of San Francisco and the decrement throughout the United States would be proportionately the same. This speaker quoted the number of dentists in 1922 as being 62,000 and the number in 1932 as 58,000. His source of information for these figures was not mentioned.

At any rate the accuracy of these figures can be questioned in view of a recent publication of the United States Department of Commerce.[2] In a table showing the number of persons engaged in curative professional service it is stated that there has been an *increase* in the number of dentists every year since 1929. In 1929 the number was 57,218, in 1932 there were 60,500, while in 1934 the number had grown to 63,452. The income, however, of this group had *decreased* in this same period 32.3 per cent from $4,564 in 1929 to $2,787 in 1934. This decrease in income, however, can hardly be interpreted as a result of overcrowding in the field but rather it reflects the general unfavorable economic picture.

We have been told on many occasions that figures do not falsify but that the interpretations from them may be false. In this case the figures themselves do not agree and the interpretations are exactly opposite. The dental college dean used his figures as a plea to stimulate dental education: "Your Committee feels that it is time

[1]Doctor T. E. Purcell, Dean, University of Saint Louis.
[2]National Income in the United States, 1929-1935, United States Department of Commerce, Washington, United States Government Printing Office, Page 212, 1936.

serious thought was given dental education lest we as a profession perish." The *Chicago Tribune*[3] using the figures of the United States Department of Commerce made this interpretation: "In the curative professions . . . the evidence of overcrowding is much more pronounced . . . The time when a professional education will not pay for itself is not far off, indeed, if it is not already here."

". . . For an improving standard of living we need more machinists and plasterers, and might profitably divert some budding professionals to provide recruits for those trades. A better distribution of people between professions and trades is urgently needed."

There are the arguments! Dental educators urge us to turn out more dentists; editorial writers using the figures of a federal economic research project tell us to keep young people out of the professional fields and divert them to the trades. Regardless of the facts more people will see and be influenced by the statements and interpretations made from the Department of Commerce study than by the statement of dental educators. If there is an increasing shortage of dentists that may grow to perilous proportions in the next fifty years, it is regrettable if the dental educators must battle against a hard group of figures such as those shown in the governmental study.

We should all like to know what the situation is—if there are more or fewer dentists; if there is danger of overcrowding or a shortage. Our last audited circulation figures[4] for this magazine show that there are 64,219 dentists in private practice, a figure much closer to the Department of Commerce figure than to that quoted by the dental educator. We do not claim infallibility for our circulation list, but we do believe that it is the most accurate and complete list now available. It was used by the Committee on the Study of Dental Practice in cooperation with the studies of the Committee on the Costs of Medical Care. It has been used frequently by dental societies and dental colleges. Six full-time employees are kept constantly at work in our circulation department adding to and making changes in this list by consulting local dental dealers and reviewing city directories, telephone installations, dental license registrations, and obituaries. We believe that our list, although not perfect, is the best available in the dental field. It does not indicate that the number of dentists is decreasing; it does not suggest that we are faced

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[3]Editorial, The Professions, Chicago Sunday Tribune (December 6) 1936.
[4]Report of Controlled Circulation Audit, Inc., New York, N. Y., (dated October 2, 1936) for six months ending August, 1936.

with any immediate shortage in the dental productive field.

In many respects we cannot do anything except agree with the implication in the statement made by the dental dean. It is simple arithmetic to see that, if fewer and fewer persons graduate each year from dental colleges, a time will come when the yearly replacements will not balance the number lost by death and retirement. At first there would be moderate shortage which would within a short time become acute. When this stage was reached there would be a rapid movement of young people into dental colleges. Consequently any statement made regarding the number of dentists is without full meaning unless we know more about the age and practice expectancy of this number. For instance, if a large per cent of the 63,000 dentists in practice in 1934 were past 50, the dental shortage would come soon; if they are under 50, the shortage, provided replacements do not balance retirements, will be longer deferred. A dental census giving this kind of actuarial information would be valuable.

Edward J. Ryan

INDIANA SPONSORS "THE DENTIST SAYS"

At the suggestion of Doctor Mary H. Westfall, Dental Health Educator, Bureau of Maternal and Child Health of the Indiana State Board of Health, the State Department of Public Instruction of Indiana has, after critical study and satisfactory trial, introduced the Tuesday broadcasts from the radio program "The Dentist Says,"[1] in printed form, to about 700 schools scattered about the state. The Bureau is looking toward a much wider distribution of the program next fall.

This program has been astonishingly successful in inspiring children to keep their mouths clean and to have restorations placed in decayed teeth or necessary extractions made. It now forms part of the instruction in more than 5,000 schoolrooms in twenty states.

[1]Clapp, G. W.: Help Yourself to a Practice, ORAL HYGIENE 26A:1447, 1598 (November and December) 1936.

Ask ORAL HYGIENE

Please communicate directly with the Department Editors, V. CLYDE SMEDLEY, D.D.S., and GEORGE R. WARNER, M.D., D.D.S., 1206 Republic Building, Denver, Colorado, enclosing postage for a personal reply. Material of general interest will be published each month.

Adjusting Dentures

Q.—I should appreciate having any possible aid in the following case:

A woman, 49, presented herself at the office wearing an upper vulcanite denture. She showed bilateral grooving or splitting of the angles of the lips. The anterior part of the ridge was flabby with a groove between the border ridge and muscle attachments; the upper ridge was highly inflamed; the lower anterior teeth were in position; and the tissue firm.—E. A. H., Ohio.

A.—This case seems to be typical of a group of mouths that we see with the anterior part of the upper jaw badly traumatized with more or less inflammation of the mucous membrane and the bone largely resorbed because of this pounding trauma from the unbalanced and concentrated occlusion of a few remaining lower anterior teeth. This is the condition that leads some dentists to advise the extraction of all lower anterior teeth when they are the only teeth remaining in the mouth. I am of the opinion, however, that it is best, in most cases, to retain these teeth and supply the posterior teeth with a tooth and tissue supported type of partial denture.

The groove that you speak of is due, no doubt, to this resorption of the bony support with a pushing forward of the flexible gum tissue. In some cases it is no doubt advisable to remove this flabby unsupported gum tissue and to reduce the bony ridge also (where it has resorbed to a knife edge or sharp spicular condition) down to a firm rounded base, for it is simpler to fit a flat mouth with comfort and satisfaction than one in which the bone is sharp enough to cut into the gum underneath upon the slightest pressure. But whether the jaw is operated on or not, new dentures should be made, providing the heaviest occlusion on the posterior teeth and eliminating cusp interference to avoid lateral trauma.—V. C. SMEDLEY.

Itching Gums

Q.—A patient, a woman, recently had all her upper teeth extracted without any difficulty. She still has ten or eleven lower teeth left and all of them seem to be in good condition, but since having her upper teeth extracted her lower gums itch so severely that it has been necessary to give her a narcotic so she can get rest and relief.

What is the cause of this condi-

tion and what treatment do you suggest?—E. A. H., Ohio.

A.—It would seem to me that the itching which your patient experiences is a result of a disturbance of circulation and nerve function from the extraction. I would anticipate that when you have placed the dentures this itching sensation will disappear.

In making the dentures be sure that you have the bite open wide enough so there will be no impingement upon the nerves around the temporomandibular joint, because it is probably in this region that the impingement occurs at the present time on account of the loss of support because of loss of the teeth. —GEORGE R. WARNER.

Bleaching Teeth

Q.—Will you please tell me what to use and the method of bleaching an upper central incisor?—D. M. L., Ohio.

A.—My advice is to sterilize and fill the apical two-thirds of the canal, enlarge the pulp chamber considerably, fill with loose cotton, and seal it in with hot temporary stopping. With a hot blunt instrument, melt a hole through the center of the temporary stopping and carry several drops of Pyrozone (25 per cent ethereal solution of hydrogen peroxide supplied in sealed ampules) between the beaks of long nosed operating pliers into the cotton that is filling the pulp chamber. Seal it in by fusing the hole through the temporary stopping. Sometimes one such application will suffice. Seldom more than three at two or three day intervals will be required.—V. C. SMEDLEY.

Pain in Teeth

Q.—I have a case which is causing me some concern as to its etiology.

A young woman in her thirties complains of an acute pain when she masticates on the right side. As she describes it, it seems like galvanic action, yet there is no apparent cause. The teeth appear to be normal with no abraded surfaces. There are two amalgam restorations on the right side; one above in the six year molar, and a larger one in the lower six year molar. Both teeth are vital. I removed both of these restorations and in the lower one I cut away the horn of the pulp and placed a thymol preparation over the pulp and filled it temporarily with gutta percha, but with no apparent results. My patient seems to think that by pressing on the lower molar lingually she can produce this pain. There is no soreness and there is nothing to aid in a diagnosis. I know you will probably think that I have overlooked an abraded surface, but I assure you I have sought diligently for that. Can you explain the cause of this condition? H. C. V., New York.

A.—In the case you report one would naturally think of a hyperemia of the pulp due to the cutting away of the horn of the pulp and then putting in a gutta percha filling. Gutta percha is likely to make a tooth sore so that it is sensitive during mastication. Then there is a possibility of a mesial-distal crack in this tooth. To detect such a crack, it is necessary to remove all restoration material and to dry the tooth thoroughly, even

to the point of dehydration, and examine the base of the cavity with a bright light. I had such a case about two yars ago for which I finally made an inlay with pins on the buccal and lingual so that the lateral halves of the tooth would be tightly bound together. I saw the patient recently and she says the tooth is perfectly comfortable.—GEORGE R. WARNER

KEEP YOUR OFFICE CLEAN

(*Continued from page* 343)

his show cases besides a semi-weekly floor and window washing.

He knows that his merchandise shows to best advantage in a shop not only well arranged but also clean. Just as truly do Doctor Billiards' ability and services show to best advantages against a background that is not only well equipped and attractively furnished but kept immaculate.

Once upon a time there was a good dentist who, so far as his wife was concerned, had only one fault. This was a tendency to disorder, but at home she gave this minor failing little thought, and certainly had no wish to reform so good a man.

One cold snowy afternoon, however, she dropped in at his office, and it was looking bad, indeed. Not only had her husband neglected to clean up after a morning extraction, but the whole place looked as though it had not been picked up after last week's tooth extractions.

His wife felt it necessary to gently chide her husband on the state of affairs, particularly, because at the moment, ensconced in his swivel chair, his feet on the desk, he was engrossed in the new *Collier's*. Not wishing to be disturbed he replied, "Nobody is going to come in on a day like this. Business has been terrible all week."

No sooner said than into the room walked Mrs. Fastidious, and here the story may end.

Small town dentists are well aware that a large percentage of their patients come without appointment. They know that they must be prepared at all times to receive patients. To those who say "I did not know she was coming" or "I was too busy" or "I can't afford a dental nurse," I merely repeat "A smartly equipped office is effective only when it is clean and neat."

DEAR ORAL HYGIENE:

"I do not agree with anything you say, but I will fight to the death for your right to say it."—VOLTAIRE

Cash and Carry

I have read with a great deal of pleasure the article[1] CASH AND CARRY, by Doctor Ammons in the January ORAL HYGIENE. If this incident really happened in his practice, I certainly want to shake his hand, for I, like all other dentists, have had many patients on whom I would like to have used the same technique.

Before any readers attempt this drastic method of turning all dissatisfied denture wearers into satisfied ones, they had best look up the law on this in their particular state. The law in most states is that the dentures, once delivered to the patient, become his property, and if you took them away from him you might be inviting a law suit.—GEORGE W. MATTHEWS, D.D.S., *Protective Life Building, Birmingham, Alabama.*

John P. Buckley, D.D.S.

The following letter was sent to Doctor John P. Buckley.

"As secretary of this local organization, which is dedicated to the economic and social well-being of the dentist and the community, I have been directed to take this opportunity to congratulate you for your great service to society at large and California in particular.

"ORAL HYGIENE[2] too deserves a great deal of commendation for publicizing this great contribution to social service of a rare nature. As for you, Doctor Buckley, it requires a great deal of courage and an innate greatness to sacrifice so much for the cause of good government.

"We hope this will be the beginning and that, in the future, professional people will take a keener interest in civic affairs, not for purposes of personal aggrandizement but for an altruism personified by you."—JULIUS JAFFE, D.D.S., *Secretary-Treasurer, South Bronx Dental Chapter, Bronx, New York.*

A Reply to Doctor Nelson

It is absolutely amazing the way most dentists choose to use their assistants as buffers. If Doctor Nelson could but realize, his article[3] is a direct sock to his fellow dentists. In order of his classifications, let us see why.

THE ESCAPIST TYPE

The doctor can't afford an experienced girl, so he will hire a very young girl just out of school. Her natural young spirits are dampened when the doctor says, "Now Miss Jones, remember this is a professional office and dignity must be upheld."

[1]Ammons, O. C.: Cash and Carry, ORAL HYGIENE 27:54 (January) 1937.

[2]Woodward, C. M.: "The Most Courageous Citizen of Los Angeles," ORAL HYGIENE, 26A:1440 (November) 1936.

[3]Nelson, H. A.: The Dental Assistant in the Role of Receptionist, ORAL HYGIENE, 27:173 (February) 1937.

If you can remember your old family doctor and his severe unbending attitude, you'll realize how Miss Jones felt about professional dignity. Youth is youth and after a few friendly openings from patients, she is bound to let go. The doctor wouldn't tell her the difference between friendliness and gushing—Oh No—that's beneath *his* dignity. Miss Jones probably went to the movies and saw "Ladies in White." At her age she is naturally a mimic, and didn't you notice how beautifully Loretta Young's lashes were made up and how luscious her mouth was. All the coy glances at patients, doctors and internes—why Miss Jones had a natural pattern to follow.

If your work is not interesting, and how can it be if nothing is explained, can you help being bored?

THE SLUGGISH TYPE

Has Doctor Nelson stopped to consider that sluggish people are not well people? That there is something basically wrong. A little sympathy, a few adroit questions, a chance to take a walk during her lunch hour (most dentists seem to think their assistants don't have to eat, and if they do, why fifteen minutes is enough, the rest of the hour being spent at the bank or the post office or running the doctor's errands) would make quite a difference. Increase her salary. After all $12.00 a week is hardly enough to live on. Reduce her working hours. Why some men think their girls have to work from nine to nine is beyond anyones intelligence.

Strange as it may seem to Doctor Nelson, there are some doctors who don't want their assistants to talk to patients. The result is that a girl may seem sulky and unless she is thoroughly experienced and accustomed to the idiosyncrasies of dentists, she is a very unhappy girl, and I too, pity her.

THE CARELESS DRESSER

Why any doctor should have in his office a girl who is as sloppy as Doctor Nelson describes is beyond comprehension. Unless, of course, the doctor himself is like that.

Then, again, there are men who want their girls to dress so. Business is not so good and they feel—well maybe if the girl goes out with the male patients more business will come in. And Doctor Nelson, have you ever heard that business and pleasure don't mix?

THE COMPETENT ASSISTANT

As Doctor Nelson says—fortunately this last group includes the majority. Fortunately, because there are men who insist upon cleanliness, because there are men who will go out of their way to teach their assistants, because there are men who are kind, courteous and thoughtful. These men pay a living salary and don't argue about the additional thirty-five cents when the girl changes her uniform three times a week. He doesn't say "Let the patients read whatever we have, I'll not spend any money for new magazines." He doesn't ask the girl to mind her professional dignity or to be over friendly, and as a result the girl is her natural self.

The doctor is the one who sets the example. If he is neat, courteous, friendly and thoughtful, his assistant will naturally follow suit.—Joan Wallace, 42 West Sixtieth Street, New York, New York

BEG YOUR PARDON

THE WELL received article JU-JUTSUING TRADE, published in the January, 1937, issue of ORAL HYGIENE, was written by Joseph H. Stele, D.D.S., a former and well known contributor to this magazine. We wish to apologize to Doctor Stele and to our readers for incorrectly calling him John H. Stele.

"My dentist was a fine fellow. Each time he extracted a tooth he gave me a glass of whiskey."

"Don't you go to him any more?"

"I haven't any more teeth left."

o

Ashes to ashes,
And dust to dust,
But if it weren't for paint,
These women would rust.

o

Mary: "That husband of mine is a worm."

Sally: "Yes, I just saw a chicken pick him up."

o

The negro was being examined for a driver's license:

Investigator: "And, what is the white line in the middle of the road for?"

Negro: "Fo' bicycles."

o

Movie Actress: "I want to get a divorce."

Lawyer: "For what reason?"

Actress: "Dear me, do you have to have a reason?"

Harold: "I read in a book that Apollo was chasing a nymph and she turned into a tree."

Charles: "He was lucky. The one I'm chasing always turns into a jewelry store or a restaurant."

o

It was her first attempt at cooking, and when her husband came home, he saw a very long pie on the table.

New Husband: "What in the world is that, dearest?"

New Bride: "I couldn't get any shorter rhubarb."

o

The following inscription is on a tombstone in a Maine cemetery: "Sacred to the loving memory of James H. Ransom, who died Aug. 6th, 1800. His widow, aged 24, possessing every quallfication for a good wife, dwells at Monmoth street, this village."

o

While many people find the words and phrases relating to the transfer of property somewhat confusing, there are few who are quite so at sea as the little widow who sought out the Probate Judge at the court house one morning.

"Are you the Judge of the Reprobates?" she asked, timidly.

"Well, I am the Judge of the Probate," replied the Judge with a kindly smile.

"Oh, I guess that is what I mean." The widow went on hurriedly, "My husband died detested and left seven little infidels and I would like to become their executioner."